STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	ETED
		155689	B. WING			07/22/	2014
			B. WINC		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			OLLEGE AVE		
COURTY	COURTYARD HEALTHCARE CENTER				EN, IN 46526		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	I	PREFIX			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K010000							
	_	ode Recertification and	K010	0000	Please accept this Plan of Correction as our facility's		
		Survey was conducted by			Credible Allegation of Complia	nce	
		e Department of Health in			for our Life Safety Code		
	accordance with	1 42 CFR 483.70(a).			Recertification and State		
	Survey Dates: (07/21/14 and 07/22/14		Licensure Survey conductedon 7/21/2014 and 7/22/2014. Submission of this Plan of Correction is not an admission			
	Facility Number	r· 000091			Courtyard Healthcare Centerth	•	
	Provider Number				the deficiencies alleged in the	iat	
	AIM Number: 100290080				survey are accurate or that the	ey	
	Alivi Nullioci.	100290080			depict the level of safety and		
	G 5				security provided to the reside	nts	
		nis Austill, Life Safety			of our facility. This Plan of		
	Code Specialist				Correction is being submitted		
					solely because doing so is required by State and Federal		
	At this Life Safe	ety Code survey,			l law.		
	Courtyard Healt	thcare Center was found			iaw.		
		ce with Requirements for					
	•	Medicare/Medicaid, 42					
	•	33.70(a), Life Safety from					
	•	00 edition of the National					
		Association (NFPA) 101,					
	_	e (LSC) and 410 IAC					
		nal section of the building					
	consisting of the	e A Wing, B Wing, the C					
	wing and the ma	ain dining room was					
	surveyed with C	Chapter 19, Existing					
	Health Care Occ	_					
		1					
	This one story f	acility was determined to					
	-	11) construction and was					
	J 1	d with the exception of a					
	storage shed on	the roof. The facility has					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

000091

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	(X2) MU A. BUIL B. WING	DING	NSTRUCTION 01	(X3) DATE : COMPL 07/22 /	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	in the corridors a corridors. The re provided with sin smoke detectors.	em with smoke detection and in areas open to the esident rooms are ngle station, hard wired The facility has a and had a census of 156 s survey.						
	access were sprin a storage shed or sprinklered and t sized storage she	residents have customary nklered. The facility had a the roof that was not wo detached, garage ads used for storage by were not sprinklered.						
		by Robert Booher, Life cialist-Medical Surveyor						
		found not in compliance entioned regulatory evidenced by the						
K010018 SS=E	than required encl openings, exits, or substantial doors,	orridor openings in other						

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Event ID:

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Facility ID: 000091

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i i		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155689	B. WING		07/22/2014
NAME OF I	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	NO VIDER OR SUPPLIER	•	2400 C	COLLEGE AVE	
	ARD HEALTHCAR			EN, IN 46526	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	-	g fire for at least 20			
	minutes. Doors in sprinklered buildings are only required to resist the passage of				
		no impediment to the			
		rs. Doors are provided			
		able for keeping the door			
		ors meeting 19.3.6.3.6 are			
	permitted. 19.3.	6.3			
	Roller latches are	prohibited by CMS			
		ealth care facilities.			
	I -	ation and interview, the	K010018	K018	08/21/2014
		ensure 3 of 3 sets of	12010010	Facility will equip the three	00/21/2011
	1	doors closed and latched		corridor doors noted in the	
				2567 with automatic slide bolt	ts
	1	to the door frame. This		that meet the NFPA	
	_	e could affect at least 15		requirements. Corrective Actions: The corridor doors	
		he Main Activity room,		noted in the 2567, namely the	
	_	the Cedars lounge as well		leading to the Activity Room,	
	as staff and visite	ors.		Cedar Wing Lounge, and the	
				Birch Wing Lounge—will	
	Findings include	s:		be modified so as to meet the	:
				NFPA requirements. How	_
	Based on observ	ations with the		Others Identified: These are the only three sets of corridor	
	Maintenance Dir	rector on 07/21/14 from		doors of this type in the facility	
		p.m., and with the		As noted in the 2567, residen	
	_	ing on 07/22/14 at 10:10		those rooms may be affected	·
		ectivity room, Birch		this alleged deficient practice.	
	1	Cedars Lounge were		Preventative Measures:	
	_	-		Once equipped with the automatic slide bolts, these th	uree
	•	set of double corridor		doors will be placed on a	
		with a slide bolt latch on		Preventive Maintenance	
		had to be manually		Schedule, along with the repa	nired
		the other door to latch		laundry door noted under "K0	
		r. The Maintenance		where they will be checked to	
	Director at the ti	me of observation of the		assure that they latch	,,ill
	Activity room an	nd Birch lounge and at		appropriately. These checks we occur weekly for the next six	WIII
	the exit conferen	ice on 7/22/14 at 1:30		months, at which time their	

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i de la companya de					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED		
		155689	B. WING		07/22/2014		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE				
COURTYARD HEALTHCARE CENTER			GUSF	IEN, IN 46526			
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	p.m. acknowledged the doors would require manual latching. 3.1-19(b)			frequency may be reduced at a direction of the facility's QAPI Committee. Monitoring: The results of the PM checks noted under "Preventive Measures" (above will be submitted to the facility' QAPI Committee for review on monthly basis for the next six months. Date of Completion August 21, 2014 IDR requested as the facility believes that these three root are not covered by this regulation.	e) s a		
K010025 SS=B	least a one half ho accordance with 8 terminate at an atr protected by fire-ra glass panels and s of two separate co on each floor. Dan duct penetrations ducted heating, ve conditioning syste 19.1.6.3, 19.1.6.4 Based on observe facility failed to barriers on Ceda maintain the fire smoke barrier. I requires the pass materials such as protected so that	e constructed to provide at our fire resistance rating in .3. Smoke barriers may firm wall. Windows are lated glazing or by wired steel frames. A minimum ampartments are provided in pers are not required in of smoke barriers in fully entilating, and air ms. 19.3.7.3, 19.3.7.5, ation and interview, the ensure 1 of 3 smoke in swing was protected to resistance of each LSC Section 8.3.6.1 age of building service is pipe, cable or wire to be the space between the	K010025	K025 Facility will continue to ensure that smoke barriers are constructed to provide at least one half hour fire resistance rating in accordance with 8.3. Corrective Actions: The smothartier penetration noted during the survey has been repaired. How Others Identified: As	oke		
	•	and the smoke barrier		noted in the 2567, this alleged deficient practice could affect	i i		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER			ULTIPLE CO LDING	INSTRUCTION 01	(X3) DATE SURVEY COMPLETED		
		155689	B. WIN			07/22/2	2014
	PROVIDER OR SUPPLIEF			2400 C	ADDRESS, CITY, STATE, ZIP CODE OLLEGE AVE EN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	maintaining the smoke barrier or approved device purpose. This deaffect at least 10 wing as well as a from a fire were protective barrier. Findings included Based on observe Administrator are on 07/22/14 at 1 exposed penetration by carrier wing, Center has the ceiling tile we penetration by carrier was not firestopp at the time of ob Administrator are	ation with the ad Maintenance Director 0:50 a.m., there was an tion through the Cedar II, smoke barrier above there a one inch able through the drywall ped. Based on interview servation, the ad Maintenance Director are unprotected opening			residents on Cedar Wing. Preventative Measures: Smoke barriers have been pla on a schedule whereby they we be visually checked for compliance with K025, monthly, as a part of the facility Preventive Maintenance schedule. Documentation of these observations will be forwarded to the facility's QAP Committee for review. Monitoring: The results of the visual checks completed unde "Preventive Measures" (above will be reviewed by the facility' QAPI Committee at each mee it holds in the next six months. Date of Completion: August 21, 2014	rill ty's I e r) s ting	
K010029 SS=A	hour fire-rated doc automatic fire exti	DDE STANDARD d construction (with ¾ ors) or an approved nguishing system in 3.4.1 and/or 19.3.5.4					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155689	B. WIN			07/22/2014	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			OLLEGE AVE		
COLIRTY	ARD HEALTHCAR	PE CENTER			EN, IN 46526		
					1 10020		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ſΈ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	is areas. When the					
		tic fire extinguishing used, the areas are					
		her spaces by smoke					
		s and doors. Doors are					
		on-rated or field-applied					
		hat do not exceed 48					
		ottom of the door are					
	permitted. 19.3	.2.1					
	Based on observ	ration and interview, the	K01	0029	K029 Facility will continue to		08/21/2014
	facility failed to	ensure 1 of 5 doors			ensure that doors serving		
	serving hazardo	us areas such as a laundry			hazardous areas, such as		
	_	ed to prevent the passage			laundry, close and latch to prevent the passage of smoke		
		deficient practice			Corrective Actions: The		
		vice hall and would not			laundry door has been repaire	d	
					so that it closes and latches to		
	-	esidents but would affect			prevent the passage of smoke	, in	
	staff.				accordance with K029. How		
					Others Identified: As noted i		
	Findings include	· ·			the 2567, the door found out o		
					compliance is in a service hall		
	Based on observ	ration with the			and would not affect residents Preventative Measures:		
	Maintenance Di	rector on 07/21/14 at			This door, along with the three		
		oor to the clean laundry			noted under "K018", will be		
	-	but did not latch into the			placed on a Preventive		
					Maintenance Schedule, where	it	
		n interview at the time of			will be checked to assure that	it	
	,	Maintenance Director			latches appropriately. These		
		ne clean laundry room			checks will occur weekly for th		
	door did not late	th to prevent the passage			next six months, at which time their frequency may be reduced		
	of smoke.				at the direction of the facility's	u	
					QAPI Committee. Monitoring	a:	
	3.1-19(b)				The results of the PM checks	<i>'</i>	
	,				noted under "Preventive		
					Measures" (above) will be		
					submitted to the facility's QAP	i	
					Committee for review on a		
					monthly basis for the next six	.	
					months. Date of Completion	:	

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Facility ID: 000091

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AND PLAN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155689		A. BUI	A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD		(X3) DATE SURVEY COMPLETED 07/22/2014	
	PROVIDER OR SUPPLIEF ARD HEALTHCAR			2400 COLLEGE AVE GOSHEN, IN 46526			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K010038 SS=E	readily accessible with section 7.1. Based on observer facility failed to delayed egress lewith NFPA 101, in any egress path 101, 19.2.2.2.4, 13 egress paths. could affect at leas staff and visit. Findings included Based on observe Nursing on 07/2 Cedars Annex conceders Annex concede	anged so that exits are at all times in accordance 19.2.1 ation and interview, the ensure not more than one ock device complying 7.2.1.6.1 was provided the as permitted by NFPA Exception No. 2 in 1 of This deficient practice that 10 residents as well ors. Exact 10 residents as well ors.	K01	10038	K038 Facility will continue to have its exits arranged so as to be readily accessible at all time. Corrective Actions: The Cedar Wing Annex doors have been rearranged so as to prove only one delayed egress. To so, the delayed egress on the set of doors has been remove. How Others Identified: As noted in the 2567, this alleged deficient practice could affect least 10 residents. Preventa: Measures: Maintenance Supervisor has been trained of the delayed egress requiremented in "K038". Monitoring: All Code Alert (if Wanderguarded) doors are checked for proper functioning a weekly basis. As the door if question is now equipped with Code Alert, it will be checked proper functioning weekly alor with the rest of the Code Alert doors. These door checks will submitted to and reviewed by facility's QAPI Committee for the next six months. Date of Completion: August21, 2014 IDR requested as facility does not believe that this area, as is used, is in violation of K03	to des. e e vide do 1st d. I at tive on no for no libe the the the stit	08/21/2014

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING O1			ETED	
		155689	B. WIN			07/22/	2014
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			2400 C	OLLEGE AVE		
COURTY	ARD HEALTHCAR	E CENTER		GOSHE	EN, IN 46526		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
SS=C	LIFE SAFETY CO	plan for the protection of					
	·	their evacuation in the					
	event of an emerg						
		review, observation and	K01	0048	K048 Facility will continue to		08/21/2014
		cility failed to develop a			have a written plan for the		
		y plan to address staff			protection of all patients and for		
		ctivation of hard wired,			their evacuation in the event o	-	
	-	oke detectors installed in			emergency. Corrective Action Facility's Fire Safety Plan has		
	-	ent sleeping rooms. LSC			been amended to include		
					instructions as to what staff is	to	
	•	a written health care			do in the case of a hardwired		
	occupancy fire safety plan shall provide				smoke detector being		
	for the following				activated. How Others	4	
	(1) Use of alarms				Identified: This alleged deficiently practice has the potential to af		
	` ′	of alarm to the fire			all of the facility's	ieci	
	department				residents. Preventative		
	(3) Response to a	alarms			Measures: Staff will be trained	l on	
	(4) Isolation of fi	ire			how to react when a smoke		
	(5) Evacuation o	f immediate area			detector audibilizes. Facility w	rill	
	(6) Evacuation o	f smoke compartment			begin incorporating smoke detector audibilization into its I	Eiro	
		of floors and building for			Drill schedule, with three such		
	evacuation	C			drills being held, one on each		
	(8) Extinguishme	ent of fire			shift, over the next three month	hs,	
		actice could affect all			to ensure that staff react		
	residents, staff a				appropriately to the audible	>=:II	
	residents, stair a	id visitors.			smoke detector signals. Fire I Report will be amended to	וווזע	
	Eindings include				indicate whether the drill in		
	Findings include	•			question was one that was		
	D 1 .	Cal Ni . II			initiated by the "fire indicator" of	or a	
		of the Nursing Home			"smoke detector		
		Status Report (State			signal". Monitoring: Fire Drill	nd	
	_	-13]) completed by the			Reports will be submitted to, a reviewed by, facility's QAPI	iiu	
		rector on 07/21/14, the			Committee for the next six		
	form indicated th	ne hard wired smoke			months. Date of Completion:		
	detectors provide	ed in each resident room			August 21, 2014		
	provided a visua	l and audible signal at					

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A. BUILDING	IPLETED
155689 B. WING	22/2014
STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER 2400 COLLEGE AVE	
COURTYARD HEALTHCARE CENTER GOSHEN, IN 46526	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	DATE
the nurses' stations that attend each room.	
Based on observation on 7/22/14 with the	
Maintenance Director and Administrator	
at 11:00 a.m., the hard wired smoke	
detector in room 216 was tested with	
canned smoke and when activated, did	
not send a signal to the nurses' station.	
At that time, the Maintenance Director	
amended the form. Based on interview at	
the time of observation, when asked if the	
staff's response to the hard wired smoke	
detectors in the resident rooms was	
addressed in the facility's fire and disaster	
plan, the Administrator acknowledged he	
did not know. At the exit conference on	
07/22/14 at 1:30 p.m., the Administrator	
did not provide a written fire safety plan	
to address staff response to the activation	
of hard wired, single station smoke	
detectors installed in 113 of 113 resident	
sleeping rooms.	
3.1-19(a)	
K010050 NFPA 101	
SS=C LIFE SAFETY CODE STANDARD	
Fire drills are held at unexpected times	
under varying conditions, at least quarterly	
on each shift. The staff is familiar with	
procedures and is aware that drills are part of established routine. Responsibility for	
planning and conducting drills is assigned	
only to competent persons who are qualified	
to exercise leadership. Where drills are	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 COMPLETE			ETED	
		155689	A. BUILDING B. WING 07/22/2014				2014
			B. WIN		ADDRESS OVEN STATE OF CODE		
NAME OF P	ROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP CODE		
					OLLEGE AVE		
COURTY	ARD HEALTHCAR	E CENTER		GOSHE	EN, IN 46526		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	PECTION (X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	conducted between	en 9 PM and 6 AM a coded					
announcement may be used instead of							
	audible alarms. 19.7.1.2						
	1. Based on rec	ord review and interview,	K01	0050	K050 Facility will continue to conduct Fire Drills at unexpected		08/21/2014
	the facility failed	d to ensure 7 of 7 fire					
		ne verification of			times under varying conditions	s, at	
		the fire alarm signal to			least quarterly on each shift.		
		-			Corrective Actions: Fire Dri		
	_	tation in fire drills			documentation that a signal w	. •	
		een 6:00 a.m. and 9:00			sent to and received by the	as	
	p.m. for the last	4 quarters. LSC 19.7.1.2			monitoring company. How		
	requires fire exit	drills in health care			Others Identified: All resider	nts	
	occupancies sha	ll include the			have the potential to be affecte	ed	
	transmission of	a fire alarm signal and			by this alleged deficient praction	ce.	
		nergency fire conditions.			Preventative Measures: Fire	;	
		ractice affects all			Drill Report will be amended to)	
	_				indicate whether the drill in		
		facility as well as staff			question was one that was		
	and visitors.				initiated by the "fire indicator" (or a	
					"smoke detector signal". Monitoring: Fire Drill Repor	to	
	Findings include	:			will be submitted to, and review		
					by, facility's QAPI Committee		
	Based on review	of Fire Drill Reports on			the next six months. Date of		
	07/21/14 at 11:3	_			Completion: August 21, 2014		
		rector, the documentation			IDR requested as facility		
		· · · · · · · · · · · · · · · · · · ·			believes its Fire Drills and Fi	re	
		formed between the			Drill Schedule meet the		
		m. and 9:00 p.m. for the			requirements of K050. Facilit	ty	
	past twelve mon	ths lacked verification of			also disputes the 2567's		
	the transmission	of the signal for drills			language that the "Administrat		
	conducted on 05	/30/14 at 11:00 a.m.,			questioned the requirement of	'	
		p.m., 02/28/14 at 8:00			ensuring fire drills are held at unexpected times under varying	20	
		at 4:00 p.m., 11/26/13 at			conditions". What was	ษ	
	•	0/13 at 2:00 p.m. and			questioned was how our Fire I	Drill	
	· · · · · · · · · · · · · · · · · · ·	*			schedule did not meet the	***	
	08/28/13 at 1:00	-			requirement that drills are held	d "at	
		exit conference on			unexpected times".		
	07/22/14 at 1:30	p.m., the Administrator					

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OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155689	(X2) MULTIPLE CC A. BUILDING B. WING	01	COMPLETED 07/22/2014
	PROVIDER OR SUPPLIER YARD HEALTHCARE CENTER	2400 C	ADDRESS, CITY, STATE, ZIP C OLLEGE AVE EN, IN 46526	CODE
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMPLETION
	questioned the requirement of documenting the transmission of the fire alarm signal to the monitoring station for the aforementioned fire drills.			
	3.1-19(b) 3.1-51(c)			
	2. Based on record review and interview, the facility failed to ensure 12 of 12 fire drills were conducted under varied conditions. This deficient practice affects all occupants in the facility including staff, visitors and residents.			
	Findings include:			
	Based on review of Fire Drill Reports on 07/21/14 at 11:30 a.m. with the Maintenance Director, 10 of 12 fire drills conducted over the past four quarters were conducted near the end of the month: on 1/30/14, 2/28/14, 4/30/14, 5/30/14, 6/27/14, 12/30/13, 10/29/13, 9/30/13 and on 8/28/13. Based on interview at the exit conference on 07/22/14 at 1:30 p.m., the Administrator questioned the requirement of ensuring fire drills are held at unexpected times under varying conditions. 3.1-19(b) 3.1-51(c)			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING O1 COMPLETE			ETED	
		155689	B. WING			07/22/	2014
	ROVIDER OR SUPPLIER			2400 C	DLLEGE AVE N, IN 46526		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K010056 SS=C	installed in accord Standard for the Ir Systems, to provid all portions of the Iproperly maintaine NFPA 25, Standar Testing, and Mainter Protection Sysupervised. There water supply for the sprinkler systems flow and tamper stelectrically connect alarm system. A Based on observing facility failed to automatic sprink in accordance with Systems, to provide all portions of 13, Section 5-1.1 be installed through LSC Section 9.7 automatic exting than an automatic as a water mist, of chemical foam of extinguishing systems.	matic sprinkler system, it is ance with NFPA 13, installation of Sprinkler de complete coverage for building. The system is ed in accordance with red for the Inspection, itenance of Water-Based stems. It is fully is a reliable, adequate de system. Required are equipped with water witches, which are sted to the building fire 9.3.5 action and interview, the ensure a complete ler system was installed of the NFPA 13, 1999. Installation of Sprinkler ide complete coverage of the building. NFPA is states sprinklers shall allows alternative uishing systems other ce sprinkler system such carbon dioxide, dry	K01	0056	K056 Facility will continue to ensure that a complete automa sprinkler system is installed in accordance with NFPA 13, Section 5-1.1. Corrective Actions: The eight-by-twelve foot shed noted in the 2567 habeen equipped with an automa sprinkler system. How Other Identified: This alleged defici practice has the potential to af all residents in the older part of the building. Preventative Measures: The shed sprinkler system will tested regularly by the facility's contracted fire system inspection company, along with the rest of facility's sprinkler system. Monitoring: Copies of sprinkler.	es as settic seient fect f be sion	08/21/2014

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	OF CORRECTION IDENTIFICATION NUMBER:	(x2) MULTIPLE CONSTRUCTION A. BUILDING 01	(X3) DATE S COMPLI	
	155689	B. WING	07/22/	2014
	PROVIDER OR SUPPLIER 'ARD HEALTHCARE CENTER	STREET ADDRESS, CITY, 2400 COLLEGE AVE GOSHEN, IN 46526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDE PREFIX (EACH CORRE CROSS-REFERI TAG	ER'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Such systems shall be installed, inspected and maintained in accordance with NFPA standards and shall activate the building fire alarm system. This deficient practice could affect residents, staff and/or visitors in the original section of the building. Findings include: Based on observation with the Maintenance Director on 07/21/14 from 10:15 a.m. to 11:15 a.m., a eight foot by twelve foot shed located on the roof of the original section of the building lacked sprinkler protection, or protection by an alternative extinguishing system. The shed was constructed of a wood frame and floor with an aluminum exterior and was used primarily for the storage of air handler filters. Based on interview at the time of observation, the Maintenance Director acknowledged the lack of extinguishing protection in the shed located on the roof. 3.1-19(b)	system insp will be forwa QAPI Commeach meetin months. D August 21, requested a believe that	pections and checks arded to the facility's nittee for review at ng for the next 12 ate of Completion:	DATE
K010062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	01	COMPLETED
		155689	B. WIN			07/22/2014
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER				OLLEGE AVE	
COLIRTY	ARD HEALTHCAR	E CENTER			EN, IN 46526	
					-14, 114 40020	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE
	periodically. 19. NFPA 25, 9.7.5	7.6, 4.6.12, NFPA 13,				
	i '	ation and interview the	VOI	10062	K062 Facility will continue to	08/21/2014
		ation and interview, the	KU	10062	ensure that required automatic	
	1	ensure 1 of 1 sprinkler			sprinkler systems are	, l
		tinuously maintained in			continuously maintained in	
	reliable operating	g condition. LSC 9.7.5			reliable operating condition an	d
	requires all autor	natic sprinkler systems			are inspected and tested	
	shall be inspecte	d, tested and maintained			periodically. Corrective	
	in accordance wi	ith NFPA 25, Standard			Actions: The sprinkler heads	i
	for the Inspection	· ·			noted as having paint on them—those in the closets in	
	_	Water-Based Fire			rooms #101, 117, 136, 212, ar	nd
		ms. NFPA 25, 1998			229 near the windows in reside	
		· ·			rooms #200, 218, and 228—ha	
		equires any sprinkler			been replaced. How Others	
	^	which is painted,			Identified: All sprinkler heads	III
		ed, loaded, or in the			the building have been assess	III
	improper orienta	tion. This deficient			head-by-head and each that w	III
	practice could af	fect all residents, staff			found to have paint on them ha	III
	and visitors.				been replaced. Preventative Measures: Sprinkler heads w	
					be placed on a Preventive	/III
	Findings include				Maintenance schedule whereb)V
		•			they will be checked for paint a	
	Based on observ	ation with the			corrosion every three months t	
					the next year, with the results	III
		rector from 3:00 p.m. to			this PM check being forwarded	
	_	21/14, and with the			the facility's QAPI Committee t	or
		ing from 9:30 a.m. to			follow-up and review. Monitoring: QAPI Committee	
		7/22/14, paint was noted			will review the sprinkler head	<i>'</i>
	on the sprinkler	heads in the closets of			audits for the next year. Date	of
	resident rooms 1	01, 117, 136, 229 and			Completion: August 21, 2014	
	212. Paint was r	noted on the sprinkler				
		indow in resident rooms				
		8. Based on interview at				
	· · · · · · · · · · · · · · · · · · ·	ce on 07/22/14 at 1:30				
ı	p.m., the Mainte					
	_					
	acknowledged th	ne aforementioned				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING O1		ETED		
		155689	B. WIN			07/22/	2014
	ROVIDER OR SUPPLIER		•	2400 C	ADDRESS, CITY, STATE, ZIP CODE OLLEGE AVE EN, IN 46526		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	sprinklers had pa	int on them.					
K010064 SS=A	health care occupa 9.7.4.1. 19.3.5.6 Based on observa facility failed to a fire extinguishers at periods not mo NFPA 10, the Sta Extinguishers, in extinguishers, in extinguishers sha maintenance not or when specifica monthly inspecti maintenance as a extinguisher. It is maximum assura operate effective deficient practice affect on resident Findings include Based on observa Maintenance Dir 07/21/14, the ann attached to the po	guishers are provided in all ancies in accordance with 6, NFPA 10 ation and interview, the ensure 1 of 28 portable is was given maintenance ore than one year apart. andard for Portable Fire 4-4.1 requires all be subjected to more than one year apart ally indicated by a on. 4-2.2 defines a "thorough check" of the is intended to give since the extinguisher will ly and safely. This is ewould have a minimal tes, staff and/or visitors.	K01	0064	K064 Facility will continue to provide portable fire extinguish in accordance with 9.7.4.1. 19.3.5.6, NFPA 101. Correct Actions: The fire extinguisher noted in the 2567 was replaceduring the survey. How Othe Identified: As noted in the 25this alleged deficient practice would have a minimal affect or residents. Preventative Measures: Fire extinguishers are checked monthly through the facility's Preventive Maintenan Program. The extinguisher no in the 2567—in laundry—has been added to the list of extinguishers to be checked monthly. Monitoring: The Preventive Maintenance documentation of fire extinguishers will be forwarded to the facility's QAP Committee, monthly for the ne 12 months, for review and follow-up. Date of Completio August 21, 2014	ive r d rs 667, h ce ted	08/21/2014
	indicated the last	annual maintenance					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155689	B. WING		07/22/2014
NAME OF F	PROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP CODE COLLEGE AVE	
COURTY	'ARD HEALTHCAR	E CENTER		HEN, IN 46526	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	, The state of the	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	performed in 201 at the time of ob- Maintenance Dir annual maintena	rector acknowledged the nee procedure for the portable fire extinguisher			
K010075 SS=E	do not exceed 32. The average dens a room or space d (20.4 L/sq m). A c is not exceeded w m) area. Mobile s collection receptact than 32 gal (121 L protected as a hazattended. 19.7.8 Based on observing facility failed to gallons for soiled receptacles was a 64 square foot ar protected as a haze resident rooms. could affect at less a could affect at less a council of the average density o	sh collection receptacles gal (121 L) in capacity. ity of container capacity in oes not exceed .5 gal/sq ft capacity of 32 gal (121 L) ithin any 64 sq ft (5.9-sq oiled linen or trash cles with capacities greater) are located in a room cardous area when not 5.5 ation and interview, the ensure a capacity of 32 d linen or trash collection not exceeded within any rea which was not zardous area for 1 of 113 This deficient practice ast 10 residents as well ors on the Cedars wing	K010075	K075 Facility will modify the containers it uses for Infection Control so as to adhere to K07 Corrective Actions: Facility modify the containers it uses for Infection Control so as to adhere to K075. How Others Identified: As noted in the 25th this alleged deficient practice of the potential to affect upwards 10 residents in the facility, nanothose residing in rooms where Isolation Precautions are in effort Preventative Measures: Staff has been educated on the	75. will for ere 567, has s of nely efect.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155689	B. WING		07/22/2014
	PROVIDER OR SUPPLIEF		2400 0	ADDRESS, CITY, STATE, ZIP CODE COLLEGE AVE EN, IN 46526	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	Nursing on 07/2 32 gallon containsoiled linen and of biohazardous one another in reon an interview observation, the	Director of Nursing ontainers were used for		facility's new procedures for the collection and storage of soiler and hazardous materials. Infection Control Rounds will be conducted on residents for whe Isolation Precautions are in effor to ensure that the facility remain compliance with K075. Such rounds will be completed week for the 1st four weeks, then monthly for the next 5 months then quarterly for the next six months. Monitoring: Results of the Infection Control Rounds note under "Preventive Measures" (above) will be forwarded to the facility's QAPI Committee for review and follow-up. Date of Completion: August 21, 2014 IDR requested as facility does not believe that its isolation procedures, as they were during the survey, were out of compliance with this regulation.	d pe nom fect nins sh kly d fe f 4 es
K010130 SS=C	Based on record interview; the fa preventive main wired smoke det 113 resident slee 4.6.12.2 requires features obvious required by the 6	S FICIENCY NOT ON 2786 review, observation and cility failed to maintain a tenance program for hard ectors installed in 113 of eping rooms. LSC s existing life safety to the public, if not Code, shall be either moved. This deficient	K010130	K130 Facility will continue to adhere to the NFPA requirements, as written. Corrective Actions: Facility implemented a Preventive Maintenance program for hard wired smoke detectors based the Manufacturer's Recommendations, namely the they be sprayed with canned a once per year. Smoke detector will be blown with canned air	has d on at air

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	OF CORRECTION	155689	A. BUILI		01	07/22/2014
		100000	B. WING		DDRESS, CITY, STATE, ZIP CODE	01/22/2011
NAME OF I	PROVIDER OR SUPPLIEF	₹			OLLEGE AVE	
COURTY	ARD HEALTHCAR	RE CENTER			N, IN 46526	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	*	ffect all residents, staff			before August 21, 2014. How Others Identified: As noted i	
	and visitors in th	ne facility.			the 2567, all residents have th	
					potential to be affected by this	
	Findings include	e:			alleged deficient practice.	
					Preventative Measures:	
		of the Nursing Home			Facility will implement a Preventive Maintenance progr	am
		Status Report (State			for hard wired smoke detectors	ı
	_	3-13]) completed by the			Monitoring: Preventive	-
		rector on 07/21/14 and			Maintenance documentationor	
		22/14, the form indicated			hard wired smoke detectors with a reviewed at the facility's	ill
	hard wired smok	ke detectors were			be reviewed at the facility's September 2014 and Septemb	ner
	provided in each	resident room. Based			2015 QAPI meetings. Date o	
	on observation d	luring tours of the facility			Completion: August 21, 2014	
	on 7/21/14 and (07/22/14 with the			IDR requested as facility doe	s
	Maintenance Dia	rector, Director of			not believe it was out of	
	Nursing and Ada	ministrator, the hard			compliance with its smoke detector maintenance	
	wired smoke det	tectors in each resident			requirements at the time of the	he
	room was confir	med. Based on interview			survey.	
	on 07/22/14 at 1	1:00 a.m., when asked if				
	the facility had a	a preventive maintenance				
	program for the	hard wired smoke				
	detectors in the	resident rooms, the				
	Maintenance Dia	rector indicated he				
	thought the com	pany that inspected the				
	fire alarm system	n checked them. At the				
	exit conference	on 07/22/14 at 1:30 p.m.,				
	no documentation	on was provided to				
	demonstrate the	hard wired smoke				
	detectors in the	resident rooms were				
	maintained.					
	3.1-19(a)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	a. BUILDING 01		COMPLETED	
		155689	B. WIN			07/22/	2014
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	<u>.</u>		2400 C	OLLEGE AVE		
COURTY	ARD HEALTHCAR	E CENTER		GOSHE	EN, IN 46526		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K010143	NFPA 101	DE CTANDADO					
SS=E	LIFE SAFETY CO Transferring of oxy						
	Transferring or ox	ygen is.					
	(a) separated from	any portion of a facility					
		re housed, examined, or					
		ration of a fire barrier of					
	1-hour fire-resistive construction;						
	(b) in an area that	is mechanically ventilated,					
	sprinklered, and has ceramic or concrete						
	flooring; and						
	(c) in an area post	ed with signs indicating					
		occurring, and that					
	_	mediate area is not					
	•	dance with NFPA 99 and					
	the Compressed (Gas Association.					
	8.6.2.5.2	in the second	17.01	01.10	144.0		00/01/0014
		ation and interview, the	K01	0143	K143 The facility will continue to		08/21/2014
	_	ensure 2 of 3 liquid			adhere to the requirements of		
		reas where oxygen			K143 as they relate to the		
	_	s place were provided			transferring of oxygen.		
		mechanical ventilation.			Corrective Actions: The		
	This deficient pr	actice could affect 20 of			continuous mechanical ventila		
	156 residents.				systems are operational in bot oxygen storage areas noted ir		
					the 2567. How Others		
	Finding include:				Identified: As noted in the 25	567,	
					this alleged deficient practice		
	Based on observ	ation on 07/21/14 at 3:30			the potential to affect 20 of the	;	
	p.m. with the Ma	aintenance Director and			facility's 156 residents. Preventative Measures: All		
	on 07/22/14 at 1	0:40 a.m. with the			oxygen storage areas will be		
	Director of Nurs	ing, the Birch Wing and			placed on a Preventive		
		ygen storage/transfer			Maintenance schedule to ensu		
		rided with a mechanically			that the continuous mechanica	al	
	•	n, but they were not			ventilation systems work as designed. The schedule to ch	ack	
I -		ans were checked with a			these systems will be weekly f		
		will word discound with a			the 1st three months and mon		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPL	
		155689	B. WIN	G		07/22/	2014
	PROVIDER OR SUPPLIER		•	2400 C	ADDRESS, CITY, STATE, ZIP CODE OLLEGE AVE EN, IN 46526		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID	The same training at the same training at		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	i E	DATE
	times of observar Director and the	Based on interview at the tion, the Maintenance Director of Nursing are fans were not running			thereafter. Monitoring: The Preventive Maintenance documentationon on the continuous mechanical ventilar systems will be forwarded to the facility's QAPI Committee for review and follow-up, wheneve PM check on the systems has been completed, for the next 1 months. Date of Completion August 21, 2014	tion ne er a 2	
K010144 SS=F	exercised under lomonth in accordant 3.4.4.1. 1. Based on recording the facility failed generators for 12 the requirements Standard for Empowers Systems, 99, Health Care I requirements requirements requirements as describution systems as describility of the property of	spected weekly and pad for 30 minutes per	K01	0144	K144 Facility will continue to inspect its generators weekly a exercise them under load for 3 minutes per month. Corrective Actions: Preventive Maintenance documentation of the generators has been revised so that there are two sets—one for each generator—instead of one set. Amperage has been added to the Generator PM checks. Load testing was completed and has been scheduled to be completed annually. Generators were test and found to have transfer time of 9.5 and 9.7 seconds. A secon "letter of reliability" has been requested by the facility's nature gas supplier. How Others Identified: As noted in the 25th this alleged deficient practice in the potential to affect all of the facility's residents. Preventations.	and 00 /e n ed ee :	08/21/2014

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	(X2) MU A. BUIL B. WING	DING	NSTRUCTION 01	(X3) DATE COMPL 07/22 /	ETED
	PROVIDER OR SUPPLIER			2400 C	DDRESS, CITY, STATE, ZIP CODE DLLEGE AVE N, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	of the EPS name b. Loading that r exhaust gas temp recommended by The date and time testing shall be debased on facility deficient practice residents, staff at Findings include Based on review generator month through electron Maintenance Din 11:15 a.m. to 12 determined if the requirements of 110 in that the or documented was beginning engine engine oil pressu temperature and each generator. time of record re Director acknow	not less than 30 percent splate rating. maintains the minimum peratures as a the manufacturer. The of day for required decided by the owner, operations. This is could affect all and visitors. The of the emergency splates to maintained it is media with the rector on 07/21/14 from 130 p.m., it could not be it two generators met the Chapter 6-4.2 of NFPA and information the start/end time, it could make the oil pressure, ending are, ending water the battery voltage for Based on interview at the review, the Maintenance			Measures: The Preventive Maintenance documentation, or respect to the generator, has been amended to include amperage and load. Annual lot testing has been arranged for subsequent years. Load testing will include documentation of transfer times Monitoring: Generator Preventive Maintenance documentation who be forwarded to the facility's Committee for review for each the next six months and annual thereafter. Date of Completion: August 21, 2014	oad in ng vill IAPI of al	

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8M9T21

Facility ID: 000091

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	LDING	NSTRUCTION 01	(X3) DATE COMPL 07/22 /	ETED
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE OLLEGE AVE N, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
IAU	2. Based on record the facility failed power would be emergency generator within power months. NFPA agenerator set(s) as capacity to pick minimum freque requirements of within 10 second power. Chapter requires a written performance, excrepairs for the generator for the generator month and visitors. Findings include Based on review generator month through electron Maintenance Din 11:15 a.m. to 12 of generator load past twelve monreview. Based on review, the indicated no add time documentate the second review, the indicated no add time documentate the second review.	ord review and interview, I to ensure emergency transferred to the rator within 10 seconds or loss for 12 of 12 op, 3-4.1.1.8 states shall have sufficient up the load and meet the ncy and voltage stability the emergency system Is after loss of normal 3-5.4.2 of NFPA 99 or record of inspection, percising period, and onerator to be regularly available by the authority on. This deficient fect all residents, staff	IAU			DATE

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	LDING	NSTRUCTION 01	(X3) DATE COMPL 07/22 /	ETED
NAME OF P	ROVIDER OR SUPPLIER		STREET A	DLLEGE AVE		
COURTY	ARD HEALTHCAR	E CENTER		N, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	and acknowledge time was not doo	ed generator load transfer cumented.				
	3.1-19(b)					
	to ensure the offee 2 emergency generaliable source. Edition, Standard Standby Power S	roleum gas (liquid or all) nthetic gas Level 1 installations in the probability of ffsite fuel supplies is earthquake, flood				
	energy source.	This deficient practice esidents, staff and				

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PRINTED: 08/18/2014 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
ANDILAN	155689	A. BUILDING	01	07/22/2014		
	100000	B. WING	ADDRESS CITY STATE ZID CODE	0172272011		
NAME OF F	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE			
COURTY	ARD HEALTHCARE CENTER	2400 COLLEGE AVE GOSHEN, IN 46526				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	visitors.					
	Findings include:					
	Based on interview with the Maintenance					
	Director at 11:15 a.m. on 07/21/14, the					
	fuel source for the two emergency					
	generators is natural gas. Additionally,					
	based on interview with the Maintenance					
	Director, the facility did not have a letter					
	from their natural gas provider indicating					
	the natural gas was from a reliable					
	source.					
	3.1-19(b)					
	3.1-19(0)					
K020000						
11020000						
	A Life Safety Code Recertification and	K020000	Please accept this Plan of			
	State Licensure Survey was conducted by		Correction as our facility's			
	the Indiana State Department of Health in		Credible Allegation of Complia for our Life Safety Code	ance		
	accordance with 42 CFR 483.70(a).		Recertification and State			
			Licensure Survey conductedo	n		
	Survey Dates: 07/21/14 and 07/22/14		7/21/2014 and 7/22/2014. Submission of this Plan of			
			Correction is not an admission	ı by		
	Facility Number: 000091		Courtyard Healthcare Centerth	· •		
	Provider Number: 155689		the deficiencies alleged in the			
	AIM Number: 100290080		survey are accurate or that the depict the level of safety and	Э		
			security provided to the reside	ents		
	Surveyor: Dennis Austill, Life Safety		of our facility. This Plan of			
	Code Specialist		Correction is being submitted			
			solely because doing so is			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	(X2) MULT A. BUILDIN B. WING		02	(X3) DATE (COMPL 07/22 /	ETED
	PROVIDER OR SUPPLIER		S 2	400 CC	DDRESS, CITY, STATE, ZIP CODE DLLEGE AVE N, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	not in compliance Participation in M CFR Subpart 483 Fire and the 2000 Fire Protection A Life Safety Code 16.2. The new 2 building consisti surveyed with Cl Care Occupancie This one story fa be of Type V (11 fully sprinklered alarm system with corridors and in a corridors. The re provided with six smoke detectors, capacity of 188 a at the time of thi All areas where a access were spring a storage shed on sprinklered and t sized storage she the facility that w The facility was	neare Center was found e with Requirements for Medicare/Medicaid, 42 3.70(a), Life Safety from Dedition of the National Association (NFPA) 101, E (LSC) and 410 IAC 011 addition of the Ing of the D Wing was hapter 18, New Health Its. Cility was determined to I) construction and was The facility has a fire Ith smoke detection in the Besident rooms are Ingle station, hard wired The facility has a Ind had a census of 156 Is survey. The facility had In the roof that was not I wo detached, garage I will be the survey of the roof that was not I wo detached, garage I will be the survey of the roof that was not I wo detached, garage I will be the survey of the roof that was not I wo detached, garage I will be the survey of the roof that was not I wo detached, garage I will be the survey of the roof that was not I wo detached, garage I will be the survey of the roof that was not I wo detached, garage I will be the survey of the roof that was not I wo detached, garage I will be the survey of the roof that was not I wo detached, garage I will be the survey of the survey of the roof that was not I wo detached, garage I will be the survey of th			required by State and Federal law.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	02	COMPL	ETED
		155689	B. WIN			07/22/	2014
			Э. WIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				OLLEGE AVE		
COURTY	ARD HEALTHCAR	E CENTER		1	EN, IN 46526		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K020048	following: NFPA 101						
SS=C	LIFE SAFETY CO There is a written all patients and for event of an emerg	plan for the protection of their evacuation in the ency. 18.7.1.1	K03	20048	K048 Facility will continue to		08/21/2014
	interview; the factoristic written fire safety response to the assingle station sm 113 of 113 reside 19.2.2.2 requires occupancy fire safor the following (1) Use of alarms (2) Transmission department (3) Response to a (4) Isolation of fit (5) Evacuation of (6) Evacuation of (7) Preparation of evacuation (8) Extinguishment	alarms ire f immediate area f smoke compartment f floors and building for ent of fire actice could affect all and visitors.	K02	20048	K048 Facility will continue to have a written plan for the protection of all patients and for their evacuation in the event of emergency. Corrective Action Facility's Fire Safety Plan has been amended to include instructions as to what staff is do in the case of a hardwired smoke detector being activated. How Others Identified: This alleged deficies practice has the potential to afful of the facility's residents. Preventative Measures: Staff will be trained how to react when a smoke detector audibilizes. Facility we begin incorporating smoke detector audibilization into its for Drill schedule, with three such drills being held, one on each shift, over the next three month to ensure that staff react appropriately to the audible smoke detector signals. Fire I Report will be amended to indicate whether the drill in question was one that was initiated by the "fire indicator" of	f an ns: to ent fect I on eill Fire	08/21/2014
	Based on review	of the Nursing Home			"smoke detector	ла	
	Smoke Detector	Status Report (State			signal". Monitoring: Fire Drill Reports will be submitted to, a	nd	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155689			LDING	NSTRUCTION 02	(X3) DATE COMPL 07/22 /	ETED	
NAME OF P	ROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE	-	
COURTY	ARD HEALTHCAR	E CENTER			OLLEGE AVE EN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
IAU	Form 55004[R/3 Maintenance Dir form indicated the detectors provided a visual the nurses' station. Based on observing Maintenance Dir at 11:00 a.m., the detector in room canned smoke ar not send a signal. At that time, the amended the form the time of observing th	-13]) completed by the rector on 07/21/14, the he hard wired smoke ed in each resident room. I and audible signal at the state and audible signal at the state and Administrator en hard wired smoke 216 was tested with and when activated, did to the nurses' station. Maintenance Director m. Based on interview at the vation, when asked if the too the hard wired smoke esident rooms was facility's fire and disaster strator acknowledged he to the exit conference on p.m., the Administrator wirtten fire safety plan esponse to the activation angle station smoke din 113 of 113 resident		IAU	reviewed by, facility's QAPI Committee for the next six months. Date of Completion: August 21, 2014		DATE
K020050 SS=C		DE STANDARD at unexpected times ditions, at least quarterly					

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Facility ID: 000091

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155689		A. BUI	LDING	DNSTRUCTION 02	COMPLETED 07/22/2014	
		100000	B. WIN			01722	2014
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
COURTY	'ARD HEALTHCAR	E CENTER			OLLEGE AVE EN, IN 46526		
			_		1		Q(5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
1710		e staff is familiar with		1110			DITTE
		aware that drills are part					
		tine. Responsibility for					
		ducting drills is assigned					
		persons who are qualified					
		ship. Where drills are en 9 PM and 6 AM a coded					
		ay be used instead of					
		18.7.1.2					
	1. Based on reco	ord review and interview,	K02	20050	K050 Facility will continue to		08/21/2014
	the facility failed	d to ensure 7 of 7 fire			conduct Fire Drills at unexpec		
	drills included th	ne verification of			times under varying conditions least quarterly on each shift.	s, at	
	transmission of t	the fire alarm signal to			Corrective Actions: Fire Dr	ill	
	the monitoring s	tation in fire drills			form will be amended to include	de	
	conducted between	een 6:00 a.m. and 9:00			documentation that a signal w	as as	
	p.m. for the last	4 quarters. LSC 19.7.1.2			sent to and received by the		
	requires fire exit	drills in health care			monitoring company. How Others Identified: All reside	nte	
	occupancies sha	ll include the			have the potential to be affect		
	transmission of a	a fire alarm signal and			by this alleged deficient practi	ce.	
		nergency fire conditions.			Preventative Measures: Fire		
	This deficient pr				Drill Report will be amended to indicate whether the drill in	0	
		facility as well as staff			question was one that was		
	and visitors.	3			initiated by the "fire indicator"	or a	
					"smoke detector signal".		
	Findings include				Monitoring: Fire Drill Repor		
					will be submitted to, and revie by, facility's QAPI Committee		
	Based on review	of Fire Drill Reports on			the next six months. Date of		
		•			Completion: August 21, 201	4	
					IDR requested as facility		
						ire	
	_					tv	
					I = -	ıy	
	-				language that the "Administra	tor	
		•			questioned the requirement of	f	
		•				n.a	
		at 4:00 p.m., 11/26/13 at			conditions". What was	ng	
	07/21/14 at 11:3 Maintenance Din for the drills per hours of 6:00 a.r past twelve mon the transmission conducted on 05 03/12/14 at 7:45	rector, the documentation formed between the m. and 9:00 p.m. for the ths lacked verification of of the signal for drills /30/14 at 11:00 a.m., p.m., 02/28/14 at 8:00			the next six months. Date of Completion: August 21, 201 IDR requested as facility believes its Fire Drills and Fi Drill Schedule meet the requirements of K050. Facili also disputes the 2567's language that the "Administratiquestioned the requirement of ensuring fire drills are held at unexpected times under varying the complete	4 ty tor	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155689		LDING	onstruction 02	(X3) DATE : COMPL 07/22 /	ETED	
	ROVIDER OR SUPPLIER		2400 C	ADDRESS, CITY, STATE, ZIP CODE OLLEGE AVE EN, IN 46526	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	10:00 a.m., 09/30 08/28/13 at 1:00 interview at the 6 07/22/14 at 1:30 questioned the redocumenting the alarm signal to fit the aforemention 3.1-19(b) 3.1-51(c) 2. Based on receive facility failed drills were conducted drills were conducted staff, visitors and Findings include Based on review 07/21/14 at 11:30 Maintenance Directonducted over the were conducted over the were conducted over the were conducted over the conducted	o/13 at 2:00 p.m. and p.m. Based on exit conference on p.m., the Administrator equirement of transmission of the fire me monitoring station for need fire drills. ord review and interview, a to ensure 12 of 12 fire need under varied deficient practice affects the facility including a residents. of Fire Drill Reports on the past four quarters near the end of the 4, 2/28/14, 4/30/14, 12/30/13, 10/29/13, 1/28/13. Based on exit conference on p.m., the Administrator equirement of ensuring dat unexpected times	TAG	questioned was how our Fire I schedule did not meet the requirement that drills are held unexpected times".	Drill	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	02	COMPL	ETED
		155689	B. WIN			07/22/	2014
COURTY	ROVIDER OR SUPPLIER	E CENTER	•	2400 CO GOSHE	ADDRESS, CITY, STATE, ZIP CODE OLLEGE AVE EN, IN 46526		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
K020144 SS=F	3.1-19(b) 3.1-51(c) NFPA 101 LIFE SAFETY CO Generators are insexercised under lomonth in accordar 3.4.4.1. 1. Based on record the facility failed generators for 12 the requirements Standard for Em Powers Systems 99, the Standard Facilities, Nursir requires essential systems to conford described in Chapter 3-4.4.1. monthly testing the emergency exaccordance with 6-4.2 of NFPA 1 sets in Level 1 are exercised at least minimum of 30 to following method a. Under operating conditions or at a confort the EPS name	DE STANDARD spected weekly and and for 30 minutes per nice with NFPA 99. Ord review and interview, at to exercise 2 of 2 and 2 of 12 months to meet of NFPA 110, the ergency and Standby, chapter 6-4.2. NFPA for Health Care ng Home requirements a electrical distribution arm to Type 2 systems as a pter 3 of NFPA 99. I of NFPA 99 requires of the generator serving electrical system to be in NFPA 110. Chapter 10 requires generator and Level 2 service to be at once monthly, for a minutes, using one of the ds: ng temperature not less than 30 percent	K02	.0144	K144 Facility will continue to inspect its generators weekly a exercise them under load for 3 minutes per month. Corrective Actions: Preventive Maintenance documentation of the generators has been revised to one set. Amperage has been added to the Generator PM checks. Load testing was completed and has been scheduled to be completed annually. Generators were test and found to have transfer time of 9.5 and 9.7 seconds A secon "letter of reliability" has been requested by the facility's nature gas supplier. How Others Identified: As noted in the 25th this alleged deficient practice in the potential to affect all of the facility's residents. Preventate Measures: The Preventive Maintenance documentation, we respect to the generator, has been amended to include amperage and load. Annual load.	and 80 ve In ed ee f sted es ond iral f 667, has tive	08/21/2014

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	A. BUII	LDING	ONSTRUCTION 02	(X3) DATE S COMPL 07/22 /	ETED
		10000	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	OTTEET	2011
NAME OF F	PROVIDER OR SUPPLIER				OLLEGE AVE		
COURTY	'ARD HEALTHCAR	E CENTER			EN, IN 46526		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	exhaust gas temp				testing has been arranged for subsequent years. Load testi		
		the manufacturer.			will include documentation of	iig	
		e of day for required			transfer times Monitoring:		
	_	ecided by the owner,			Generator Preventive		
		operations. This			Maintenance documentation was forwarded to the facility's Comments		
	deficient practice				Committee for review for each		
	residents, staff a	nd visitors.			the next six months and annu-		
					thereafter. Date of		
	Findings include				Completion: August 21, 201	4	
	Based on review	of the emergency					
		ly test log maintained					
	_	ic media with the					
	_ ~	rector on 07/21/14 from					
		30 p.m., it could not be					
		e two generators met the					
		Chapter 6-4.2 of NFPA					
	110 in that the or	•					
		the start/end time,					
		e oil pressure, ending					
	engine oil pressu						
		the battery voltage for					
		Based on interview at the					
	_	view, the Maintenance					
	Director acknow						
		issues regarding the					
	generator.	issues regularing the					
	generator.						
	3.1-19(b)						
	2. Based on reco	ord review and interview,					
		I to ensure emergency					
		transferred to the					
	1 *	rator within 10 seconds					

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-	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155689		A. BUILDING 02			COMPLETED 07/22/2014	
		100000	B. WIN			011221	2014
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE OLLEGE AVE		
COURTY	'ARD HEALTHCARI	E CENTER			EN, IN 46526		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	~ .	er loss for 12 of 12					
		99, 3-4.1.1.8 states					
		shall have sufficient					
		up the load and meet the					
	-	ncy and voltage stability					
	-	the emergency system					
		ls after loss of normal					
	_	3-5.4.2 of NFPA 99					
	requires a writter	n record of inspection,					
	performance, exe	ercising period, and					
	repairs for the ge	nerator to be regularly					
	maintained and a	vailable by the authority					
	having jurisdiction	on. This deficient					
	practice could af	fect all residents, staff					
	and visitors.						
	Findings include	:					
	Based on review	of the emergency					
		ly test log maintained					
	through electroni						
	_	rector on 07/21/14 from					
		30 p.m., documentation					
		transfer time for the					
		ths was not available for					
	-	n interview at the time of					
		e Maintenance Director					
	· ·	itional generator transfer					
		ion was available for					
		owledged generator load					
		s not documented.					
	uansiei tiille was	s not documented.					
	3.1-19(b)						
	J.1-17(0)						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL	
ANDILAN	OF CORRECTION	155689	A. BUI	LDING	02	07/22/	
		133009	B. WIN			011221	2014
NAME OF I	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
COURTY	'ARD HEALTHCAR	F CENTER			OLLEGE AVE EN, IN 46526		
	•			<u> </u>			975)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		erview, the facility failed					
		-site fuel source for 2 of					
		nerators was from a					
		NFPA 110 1999					
		d for Emergency and					
	· ·	Systems, Chapter 3,					
	1	er Supply (EPS), 3-1.1,					
	"	states the following					
	""	hall be permitted for use					
	0,	cy power supply (EPS):					
	a) Liquid Petrol						
	atmospheric pressure						
		roleum gas (liquid or					
	vapor withdrawa	•					
	c) Natural or sys						
	l '	Level 1 installations in					
		the probability of					
		ffsite fuel supplies is					
	_	earthquake, flood					
	damage or demo						
	_	-site storage of an					
		source sufficient to allow					
		e emergency power					
	_	EPSS) to be delivered for					
	\ 11.5.5	ed shall be required, with					
	_	comatic transfer from the					
	_	source to the alternate					
		This deficient practice					
		esidents, staff and					
	visitors.	-DISTING, DIMIT WIIM					
	, 101015.						
	Findings include	<u>:</u>					
		•					
	Based on intervi	ew with the Maintenance					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	ĺ	LDING	NSTRUCTION 02	(X3) DATE COMPI 07/22	LETED
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER				2400 C	ADDRESS, CITY, STATE, ZIP CODE OLLEGE AVE EN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	fuel source for the generators is national based on intervioral Director, the factor from their natural	5 a.m. on 07/21/14, the he two emergency ural gas. Additionally, ew with the Maintenance ility did not have a letter al gas provider indicating was from a reliable					

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